Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgement before publication.

Cerebral Malaria, Acute Renal Failure and Disseminated Intravascular Coagulation

TO THE EDITOR: The article by Faith Fitzgerald, "Malaria: A Modern Dilemma," in the March issue is a thorough review of the problem of malaria.[1] However, one approach to the rare patient who has the most fatal constellation of signs and symptoms of malaria, cerebral malaria, acute renal failure and disseminated intravascular coagulation, was not mentioned. Such patients usually have a high degree of parasitism, are very ill and need intensive supportive care. From the theoretical point of view the initial management should include the rapid elimination of the parasitized red cells and correction of the intravascular coagulation. This can easily be accomplished by large volume whole blood exchanges using heparinized blood[2-4] and has resulted in dramatic recovery of at least one such patient with severe blackwater fever.

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REFERENCES

1. Fitzgerald FT: Malaria: A modern dilemma—University of California, San Francisco, and San Francisco General Hospital (Clinical Conference). West J Med 1982 Mar; 136:220-226
2. Gyr K, Speck B, Hitz R, et al: Zerebrale Malaria tropica mit Schwarzwasserfieber Schweiz Med Wochenschr 1974 Nov 9; 104 (45):1628-1630 (Eng. Abstr.)
3. Roncoroni AJ, Martino OA: Therapeutic use of exchange transfusion in malaria. Am J Trop Hyg 1979; 28:440-444
4. Nielsen RL, Kohler RB, Chin W, et al: The use of exchange transfusions: A potentially useful adjunct in the treatment of fulminant falciparum malaria. Am J Med Sci 1979; 277:325-329

Correction: Vasopressin Infusions in Bleeding Varices

TO THE EDITOR: Your readers should be notified of a potentially serious error in the editorial on management of bleeding esophageal varices in the February 1982 issue.[1] In the fourth paragraph on page 143, vasopressin infusions should be prepared with 10 ampules of 20 U (not "200 U") vasopressin in 500 ml of 5 percent dextrose solution to make a final concentration of 0.4 units per ml.

RONALD D. ADLER, MD
Berkeley, California

REFERENCE

1. Malt RA: Management of bleeding esophageal varices (Editorial). West J Med 1982 Feb; 136:143-145

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Dr. Malt Replies

TO THE EDITOR: Dr. Adler is quite correct. Fortunately, vasopressin is available only in ampules of 20 U each, as far as I know, so no one is likely to be hurt by my error.

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Probability of Coronary Heart Disease Developing

TO THE EDITOR: Review of Erica Brittain's chart on the probability of coronary heart disease in men (in her January article[1]) shows a fall in probability from ages 65 to 70 in those with a cholesterol level of 225 through 315 mg per dl and more surprisingly a fall in probability from those with a cholesterol level under 255 to those over 255 mg per dl (in those age 70). I presume this is an error. A correction or explanation would be appreciated.

GERALD C. FREEDMAN, MD
Mill Valley, California

REFERENCE

1. Brittain E: Probability of coronary heart disease developing (Information). West J Med 1982 Jan; 136:86-89

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Ms. Brittain Replies

TO THE EDITOR: *Given the mathematical model* on which these charts (and the *Coronary Risk Handbook*[1]) are completely based, the probabilities in question are correct. The Framingham Study investigators judged this model to have an excellent fit to their data. The model includes a negative age by serum cholesterol interaction term which is responsible for the surprisingly low coronary heart disease (CHD) risk when *both* cholesterol and age are high. This reflects the finding that cholesterol is a strong coronary risk factor